

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7914 CERTIFICATE OF DEATH

07877

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Chester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>1 month 10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nottingham</b>	
3. NAME OF DECEASED (Type or print) <b>FRANK</b> First <b>ARTHUR</b> Middle <b>ADAMSON</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 8, 1906</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min. <b>53</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pump Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Water works Municipality</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Adamson</b>		14. MOTHER'S MAIDEN NAME <b>Louis Ann Ball</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-II</b>		16. SOCIAL SECURITY NO. <b>195-05-6569</b>	
17. INFORMANT <b>Elizabeth Adamson (W)</b>		18. ADDRESS <b>3 Forge Road Nottingham, Penna.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis, Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 to 12 Hrs.</b> <b>Unk.</b> <b>Unk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 6, 1960</b> to <b>July 16, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 16, 1960</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Albert L. Mooney</b>		22b. DATE <b>July 16, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALBERT L. MOONEY, M.D.</b>		22d. ADDRESS <b>VAH, Perry Point, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>7/20/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son,</b>		25a. REC'D BY REGISTRAR <b>Havre DeGrace, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>JUL 21 '60</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07878

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>N. Castle</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Port Herman</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>319 Allen Drive</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>JOSEPH FRAZIER AMADO</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>July 13, 1960</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Col.</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Sept. 22, 1940</b>		<b>9. AGE</b> (In years last birthday) <b>19 yrs.</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>School</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Phila. Penna.</b>			
<b>13. FATHER'S NAME</b> <b>Joseph Amado</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sydella Wyatt</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Mrs. Olivett Davis Wilm, Del.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Drowning</b>  <b>850X</b>  <b>DUE TO</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>(b)</b>  <b>DUE TO</b>  <b>(c)</b> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Fell or jumped off boat in Elk River, Md.</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>— 19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>River</b>			
<b>20f. (City or town)</b> <b>Cecil</b>		<b>20g. (County)</b> <b>Md.</b>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>R. C. Dodson</i>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>R. C. Dodson</b>				<b>DATE SIGNED</b> <b>7-15-60</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>22b. DATE THEREOF</b> <b>7/15/1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olive</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>PIPPIN FUNERAL HOME</b>		<b>ADDRESS</b> <b>Donald M. Du Elkton, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUL 18 '60</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Thomas</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1950		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Residence		Birthplace		Marital Status	
123 Main St, Baltimore, MD		Baltimore, MD		Married	
Date of Birth		Place of Birth		Education	
Jan 1, 1905		Maryland		High School	
Previous Illnesses		Alcohol Consumption		Tobacco Use	
None		Occasional		Occasional	
Medical History		Family History		Social History	
Hypertension		None		None	
Physician's Name		Hospital Name		Burial Place	
Dr. Smith		St. Mary's		Catholic Cemetery	
Signature of Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Examiner's Title	
Jan 16, 1950		Baltimore, MD		Medical Examiner	

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove the page and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7892

CERTIFICATE OF DEATH

Reg. Dist. No. 07879

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blkton				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah Jane Armour				4. DATE OF DEATH Month July Day 15 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1894	
9. AGE (In years lost birthday) 66 yrs.		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME -- LeSage				14. MOTHER'S MAIDEN NAME Nannie Rutter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Address Earl N. Armour, Sr North East, Md							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Chr. interstitial nephritis; chr. glaucoma; hiatal hernia duodenal diverticulum INTERVAL BETWEEN ONSET AND DEATH 12 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 22 May, 1959, to 15 July, 1960, that I lost saw the deceased alive on 14 July, 1960, and that death occurred at 3:05 AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED 15 July '60							
ACTUAL SIGNATURE Klaus H. Huebner M.D. North East, Md							
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 7-17-60							
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist							
22d. LOCATION (City, town, or county) (State) Rising Sun, R.D. Cecil Co. MD							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph R. Grant North East, Md.							
24a. REC'D BY REGISTRAR DATE 30 19 60							
24b. REGISTRAR'S SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be buried with  
the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7893

CERTIFICATE OF DEATH

Reg. Dist. No. 07880

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First William Middle Clyde Last Armour		4. DATE OF DEATH Month July Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1916
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer		10b. KIND OF BUSINESS OR INDUSTRY Penn. Railroad	11. BIRTHPLACE (State or foreign country) Wilmington, Del
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Earl N. Armour	
14. MOTHER'S MAIDEN NAME Sarah Jane LeSage		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --	
16. SOCIAL SECURITY NO. 717-09-8294		17. INFORMANT Address Mrs. William C. Armour, North East, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Chronic Glomerulonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hypertensive Cardio-vascular Disease (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 days years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 1960 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 18, 1960, to July 29, 1960, that I last saw the deceased alive on July 29, 1960, and that death occurred at 8:28 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecil Ave., North East, Md. DATE SIGNED 7-30-60			
ACTUAL SIGNATURE Luis M. Cuza, M.D.		PHYSICIAN'S NAME (Type) Luis M. Cuza, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-2-60	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist		22d. LOCATION (City, town, or county) (State) Rising Sun, R.D. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant		ADDRESS North East, Md.	
24a. REC'D BY REGISTRAR DATAUG 2 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>	
<p>3. AGE                  [REDACTED]</p>		<p>4. DATE OF BIRTH                  [REDACTED]</p>	
<p>5. PLACE OF BIRTH                  [REDACTED]</p>		<p>6. PLACE OF DEATH                  [REDACTED]</p>	
<p>7. OCCUPATION                  [REDACTED]</p>		<p>8. CAUSE OF DEATH                  [REDACTED]</p>	
<p>9. MEDICAL HISTORY                  [REDACTED]</p>		<p>10. MANNER OF DEATH                  [REDACTED]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>		<p>12. SIGNATURE OF REGISTRAR                  [REDACTED]</p>	
<p>13. DATE OF DEATH                  [REDACTED]</p>		<p>14. TIME OF DEATH                  [REDACTED]</p>	
<p>15. PLACE OF INTERMENT                  [REDACTED]</p>		<p>16. NAME OF FUNERAL HOME                  [REDACTED]</p>	
<p>17. NAME OF NEXT OF KIN                  [REDACTED]</p>		<p>18. ADDRESS OF NEXT OF KIN                  [REDACTED]</p>	
<p>19. NAME OF WITNESS                  [REDACTED]</p>		<p>20. ADDRESS OF WITNESS                  [REDACTED]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07881

7916

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>		c. LENGTH OF STAY IN 1b <b>57 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Aikin Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Virginia</b> Last <b>Burroughs</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Silas Love</b>	
14. MOTHER'S MAIDEN NAME <b>Katherine Owens</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ormond R. Burroughs, Perryville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO (b) <b>Arterio-Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>10 yrs -</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 30 1960</b> to <b>July 13 1960</b> that (I) (we) last saw the deceased alive on <b>July 13 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Clarence I. Benson</b> M.D.		22b. DATE SIGNED <b>July 14 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>		22d. ADDRESS <b>Port Deposit, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-16-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill M.E. Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Elkton, Md. Rural</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leola Patterson &amp; Son</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 18 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>

7916

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

County

Birth date

Death date

Age

Sex

Color

Place of birth

Married

Single

Widow

Divorced

Married

Single

Widow

Divorced

Married

Single

Widow

Divorced

Married

Single

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07882

7894

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk Mills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Haven Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ARNOLD</u> Middle <u>C.</u> Last <u>COOKE</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1892</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>22</u> Hours <u>1</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (weaver)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Textiles</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>William A. Cooke</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Wilson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>147-03-8140</u>				17. INFORMANT <u>Nursing home records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident with hemiplegia 8 months</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> unknown DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>0</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct. 24, 1959</u> to <u>July 5, 1960</u> that I last saw the deceased alive on <u>July 4, 1960</u> , and that death occurred at <u>9:05 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>233 E. Main Street, Elkton, Maryland</u> DATE SIGNED <u>7/5/60</u>							
ACTUAL SIGNATURE <u>Ralph Andrews, Jr.</u> M.D.				DATE SIGNED <u>7/5/60</u>			
PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS, JR., M.D.</u>				ADDRESS <u>Elkton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cecil County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u> ADDRESS <u>Elkton, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7895

## CERTIFICATE OF DEATH

07883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 5Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nurshing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George D. Crossland				4. DATE OF DEATH Month 7/25/60 Day Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug/31/1870	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Delaware		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John R. Crossland				14. MOTHER'S MAIDEN NAME Isabella Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Joseph Bryson Sr. Elkton Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute cerebrovascular accident DUE TO (b) Intertranslenticular cerebrovascular disease DUE TO (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 17, 1960, to July 25, 1960, that I last saw the deceased alive on July 25, 1960, and that death occurred at 12:20 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph Andrew Jr.				ADDRESS (Street, city or town, state) 237 E Main St Elkton, Maryland			
DATE SIGNED 7/25/60							
PHYSICIAN'S NAME (Type) Ralph Andrew Jr. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/60		22c. NAME OF CEMETERY OR CREMATORY St. Georges Cemetery		22d. LOCATION (City, town, or county) (State) St. Georges Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE G. Lester				ADDRESS Middletown		24a. REC'D BY REGISTRAR DATE JUL 28 1960	
				24b. REGISTRAR'S SIGNATURE Arthur S. Pounds			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7917

## CERTIFICATE OF DEATH

Reg. Dist. No.

07884

1. PLACE OF DEATH o. COUNTY <b>CECIL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>CECIL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RISING SUN</b>				c. LENGTH OF STAY IN 1b <b>2 WKS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>BELLE</b> Last <b>DRENNEN</b>				4. DATE OF DEATH Month <b>7/</b> Day <b>9/</b> Year <b>19 60</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/ 21/ 1889</b>	9. AGE (In years last birthday) yrs. <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWNE HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACOB W. DUNLAP</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. REYNOLDS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>S. CLYDE DRENNEN</b>		Address <b>RISING SUN, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parkinson's disease (Paralysis Agitans)</b> <b>350X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma fundus lateri</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Dec 19 57</b> to <b>July 9 19 60</b> , that I last saw the deceased alive on <b>July 8 19 60</b> , and that death occurred at <b>7:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oxford Penna</b> DATE SIGNED							
ACTUAL SIGNATURE <b>E.B. Robinson</b> M.D.							
PHYSICIAN'S NAME (Type) <b>E.B. Robinson MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-12-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WEST NOTTINGHAM CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>COLORA MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas E. McMillan</b>				ADDRESS <b>RISING SUN, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE Jul 12 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. OCCUPATION                  [Faint text]</p>	
<p>7. MARITAL STATUS                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. DATE OF DEATH                  [Faint text]</p>		<p>10. TIME OF DEATH                  [Faint text]</p>	
<p>11. PLACE OF DEATH                  [Faint text]</p>		<p>12. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>15. SIGNATURE OF CORONER                  [Faint text]</p>		<p>16. SIGNATURE OF JURY                  [Faint text]</p>	
<p>17. SIGNATURE OF JURY                  [Faint text]</p>		<p>18. SIGNATURE OF JURY                  [Faint text]</p>	
<p>19. SIGNATURE OF JURY                  [Faint text]</p>		<p>20. SIGNATURE OF JURY                  [Faint text]</p>	
<p>21. SIGNATURE OF JURY                  [Faint text]</p>		<p>22. SIGNATURE OF JURY                  [Faint text]</p>	
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<p>37. SIGNATURE OF JURY                  [Faint text]</p>		<p>38. SIGNATURE OF JURY                  [Faint text]</p>	
<p>39. SIGNATURE OF JURY                  [Faint text]</p>		<p>40. SIGNATURE OF JURY                  [Faint text]</p>	
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<p>45. SIGNATURE OF JURY                  [Faint text]</p>		<p>46. SIGNATURE OF JURY                  [Faint text]</p>	
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<p>61. SIGNATURE OF JURY                  [Faint text]</p>		<p>62. SIGNATURE OF JURY                  [Faint text]</p>	
<p>63. SIGNATURE OF JURY                  [Faint text]</p>		<p>64. SIGNATURE OF JURY                  [Faint text]</p>	
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<p>67. SIGNATURE OF JURY                  [Faint text]</p>		<p>68. SIGNATURE OF JURY                  [Faint text]</p>	
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<p>77. SIGNATURE OF JURY                  [Faint text]</p>		<p>78. SIGNATURE OF JURY                  [Faint text]</p>	
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<p>81. SIGNATURE OF JURY                  [Faint text]</p>		<p>82. SIGNATURE OF JURY                  [Faint text]</p>	
<p>83. SIGNATURE OF JURY                  [Faint text]</p>		<p>84. SIGNATURE OF JURY                  [Faint text]</p>	
<p>85. SIGNATURE OF JURY                  [Faint text]</p>		<p>86. SIGNATURE OF JURY                  [Faint text]</p>	
<p>87. SIGNATURE OF JURY                  [Faint text]</p>		<p>88. SIGNATURE OF JURY                  [Faint text]</p>	
<p>89. SIGNATURE OF JURY                  [Faint text]</p>		<p>90. SIGNATURE OF JURY                  [Faint text]</p>	
<p>91. SIGNATURE OF JURY                  [Faint text]</p>		<p>92. SIGNATURE OF JURY                  [Faint text]</p>	
<p>93. SIGNATURE OF JURY                  [Faint text]</p>		<p>94. SIGNATURE OF JURY                  [Faint text]</p>	
<p>95. SIGNATURE OF JURY                  [Faint text]</p>		<p>96. SIGNATURE OF JURY                  [Faint text]</p>	
<p>97. SIGNATURE OF JURY                  [Faint text]</p>		<p>98. SIGNATURE OF JURY                  [Faint text]</p>	
<p>99. SIGNATURE OF JURY                  [Faint text]</p>		<p>100. SIGNATURE OF JURY                  [Faint text]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7896

CERTIFICATE OF DEATH

Reg. Dist. No.

07885

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Del.</b> b. COUNTY <b>N. Castle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecil</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Elkton Union Hosp.</b>		d. STREET ADDRESS <b>1301 W. 8th Street</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES J. FAGAN Sr.</b>		4. DATE OF DEATH <b>July 25 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1894</b>
9. AGE (In years last birthday) <b>66</b>		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired railroad plumber</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Delaware</b>	
13. FATHER'S NAME <b>Peter A. Fagan</b>		14. MOTHER'S MAIDEN NAME <b>Sara Dougherty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Nora O. Fagan Wilm., Del</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion with asystole</b> DUE TO <b>10 min</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery sclerosis</b> DUE TO <b>years</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CVA due arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED <b>While</b> <input type="checkbox"/> <b>Not while</b> <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 July 60</b> , to <b>25 July 60</b> , that I last saw the deceased alive on <b>25 July 60</b> , 19____, and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace Obenshain</b>		ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>		DATE SIGNED <b>25 July 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 28, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs on the Brandywine</b>		22d. LOCATION (City, town, or county) (State) <b>Wilm., Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>DATE Jul 27 '60</b>	
ADDRESS <b>Elkton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

CENTRAL OFFICE

1908

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
FOR THE YEAR  
1908  
THE  
LAND OFFICE  
WASHINGTON, D. C.  
1909

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7897

CERTIFICATE OF DEATH

Reg. Dist. No. 07886

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN 1b <i>RURAL</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS <i>ELKTON</i>	
3. NAME OF DECEASED (Type or print) First <i>Baby</i> Middle <i>Girl</i> Last <i>Fox</i>		4. DATE OF DEATH Month <i>July</i> Day <i>29</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 29, 1960</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	9. AGE (In years lost birthday) yrs. Months Days Hours Min. <i>2 57</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Phillip Fox</i>		14. MOTHER'S MAIDEN NAME <i>Edna Mae Combs</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT <i>Phillip Fox, Elkton, Md. R.D.2</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Immaturity</i> DUE TO (c) <i>Prematurity</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/29</i> , 19 <i>60</i> , to <i>7/29</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>7/29</i> , 19 <i>60</i> , and that death occurred at <i>1:50</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Peter Stavrakis</i>		ADDRESS (Street, city or town, state) <i>154 W. Main St. Elkton, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Peter Stavrakis</i>		DATE SIGNED <i>7/29/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/30/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Head of Christiana Cemetery, Newark, Del.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 10 '60</i>	
ADDRESS <i>Elkton, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### 7918 CERTIFICATE OF DEATH

07887

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 Havre de Grace</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1224 South Washington</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <b>VERNON</b> Middle <b>K.</b> Last <b>GIBSON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-14-05</b>		9. AGE (In years lost birthday) <b>55</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>V. A.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ernest H. Gibson</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Hackney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 291-01-4507</b>		17. INFORMANT <b>Eve Gibson (W) 224 South Washington St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Myocardial fibrosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>  <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>7</b> (this hospital) attended the deceased from <b>July 2, 1960</b> to <b>July 20, 1960</b> and that death occurred at <b>7:45pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J. L. Garey</b>				22b. DATE SIGNED <b>7-21-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. L. GAREY, Clinical Pathologist, V.A. Hospital, Perry Point, Md.</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>7/23/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Havre de Grace, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 26 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. House</b>	

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RECEIVED TO THE NATIONAL ARCHIVES  
ON 10/10/2001 BY THE NATIONAL ARCHIVES  
RECEIVED TO THE NATIONAL ARCHIVES 8127

# 1 7898 7898 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07888

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eikton				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Kathryn A GORDNER				4. DATE OF DEATH Month Day Year 7 4 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26, 1898	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John C. Futtu				14. MOTHER'S MAIDEN NAME Jennie Pratt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-18-9979		INFORMANT Norman F. Gardner, Snow Hill, Maryland.	
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, Sigmoid colon 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/13, 1960, to 7/3, 1960, that I last saw the deceased alive on 7/3, 1960, and that death occurred at 1245 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Fischer				ADDRESS (Street, city or town, state) 162 W. OTAIN ST. EIKTON, MD			
DATE SIGNED 7/4/60							
PHYSICIAN'S NAME (Type) John A. Fischer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-60		22c. NAME OF CEMETERY OR CREMATORY Gordner Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Unityville, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Brant				ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1938

1938

ABSTRACT

OF THE

RECORDS

OF THE

STATE

OF

MARYLAND

FOR THE

YEAR

1938

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)  
15M 9/59

7919  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07889

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X -3	
d. STREET ADDRESS 109 I. Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JENKINS Middle J. Last HAMMONDE		4. DATE OF DEATH Month July Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-96
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Railroad-Pullman	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bunyan Hammond (deceased)		14. MOTHER'S MAIDEN NAME Cora Kitchen (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT Address Washington, D.C. David Hammond (Brother) 67 I. Street, N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic valvulitis inactive with deformity of mitral valve (mitral stenosis) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized		INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from July 5, 1960 to July 7, 1960, and that the deceased died on July 7, 1960, and that death occurred at 9:40 pm from the causes and on the date stated above.			
22a. SIGNATURE J. L. Garey		22b. DATE SIGNED 7-11-60	
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, Clinical Pathologist, V.A. Hospital, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 7/13/60	
23c. NAME OF CEMETERY OR CREMATORY Unknown National		23d. LOCATION (City, town, or county) (State) Unknown Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE JUL 19 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

7913

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

1937



Blank certificate form with faint horizontal lines and vertical columns for data entry. The form includes fields for name, age, sex, race, date of death, and cause of death. There are also sections for the attending physician and the certifying authority. The form is oriented vertically on the page.

may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

DEPARTMENT OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07890

1. PLACE OF DEATH a. COUNTY <b>CECIL</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b>		c. LENGTH OF STAY IN 1b <b>15yrs 11mos</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNA</b>		b. COUNTY <b>PHILADELPHIA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>2248 N. Chadwick Street</b>					
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>(NMI)</b> Last <b>HAYNES</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24,</b> Year <b>1960</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 16, 1914</b>		9. AGE (In years last birthday) <b>45</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth (?) Haynes</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-II</b>		17. INFORMANT <b>2248 N. Chadwick St., Mrs. Elizabeth Haynes (M) Phila., Pa.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leptomeningitis circumscribed mid brain and cerebellum</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <b>August 24, 1944</b> to <b>July 24, 1960</b> that (1) (we) last saw the deceased alive on <b>July 24, 1960</b> , and that death occurred at <b>10:AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>J. L. Garey</b>		22b. DATE SIGNED <b>7-25-60</b>		22c. PHYSICIAN'S NAME (Type) <b>J. L. GAREY, Clinical Pathologist V.A. Hospital, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Removal</b>		23b. DATE THEREOF <b>7/26/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>unknown</b>		23d. LOCATION (City, town, or county) <b>Philadelphia, Pa.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BENNYN G. &amp; SONS</b>		ADDRESS <b>Hayre DeGrace, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CENTRAL BUREAU OF DEATH

1938

DEATH CERTIFICATE

NAME

LOCAL

RESIDENCE

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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DATE OF BIRTH

TIME OF BIRTH

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DATE OF DEATH

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TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 14 FilmG268 8-8-60 et  
**CERTIFICATE OF DEATH**

7899

07891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>202 Blue Ball St.</u>				d. STREET ADDRESS <u>1 202 Blue Ball St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Nicholas</u> Last <u>Holmes</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 22, 1874</u>	9. AGE (In years last birthday) yrs. <u>86</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (retd.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Mayfield Holmes</u>				14. MOTHER'S MAIDEN NAME <u>"No information"</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-07-0778</u>		17. INFORMANT <u>Howard Holmes (Son)</u> Address <u>202 Blue Ball St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>42.0.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 22, 1960</u> , to <u>July 29, 1960</u> , that I last saw the deceased alive on <u>July 29, 1960</u> , and that death occurred at <u>2:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D.				ADDRESS <u>123 Singery Ave</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>				ADDRESS <u>Elkton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-1-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FRIENDS</u>		22d. LOCATION (City, town, or county) (State) <u>CALVERT, CEILCO, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Frank</u> ADDRESS <u>North East Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

BP



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07892

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rachel</b> Middle <b>Ann</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>7</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1869</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Haines</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Boddy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Charlotte Jones, Conowingo, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriotec- Heart Disease</b> <b>420 0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Geberla Ateriosclerosis</b> (c) <b>many yrs.</b> DUE TO (c) <b>cause lost.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>7-7-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-10-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MontZoar Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Conowingo Cecil Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Termon E. McMiller</b>				24a. REC'D BY REGISTRAR <b>Rising Sen, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Henshaw</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19  
7351 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		1912-1-15	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York		Boston		Heart Disease		Natural	
Occupation		Marital Status		Previous Illnesses		Alcohol Consumption	
Teacher		Married		None		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Remarks	
1912-1-15		10:00 AM		Home		[Blank]	

7900

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>Rural Earleville, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital Elkton, Md.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>William</b> Middle <b>H. Taylor</b> Last <b>Keen</b>				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 19, 1908</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert Keen</b>				14. MOTHER'S MAIDEN NAME <b>Laura Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>136-03-9276</b>		INFORMANT <b>Mrs. Sadie S. Keen, Earleville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Rheumatic Heart Disease with mitral stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>June 27</b> , 19 <b>60</b> , to <b>21 July</b> , 19 <b>60</b> that I last saw the deceased alive on <b>21 July</b> , 19 <b>60</b> , and that death occurred at <b>12:10 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>22 July 60</b>							
ACTUAL SIGNATURE <b>Wallace Obenshain</b>				M.D. <b>Cecilton, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>				Cecilton, Md. <b>22 July 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Perryman, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b> <b>John G. Tarring</b>				ADDRESS <b>Tarring Funeral Home</b> <b>Aberdeen, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 26 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-3

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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Source: <http://www.fishbase.org>

6. *Admission*

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*(Signature)*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7922

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>INDIANA</b> b. COUNTY <b>FT. WAYNE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT. WAYNE</b>			
c. LENGTH OF STAY IN 1b <b>4yrs 11mos 3days</b>				d. STREET ADDRESS <b>1015 SHERMAN STREET</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>D.</b> Last <b>KELLER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 9, 1908</b>		9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>IRVIN KELLER</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA WARNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>PTE</b>		17. INFORMANT <b>Mrs. Mary Aurand, Sister, 1015 Sherman St.</b>		Address <b>Ft. Wayne, Indiana</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries extreme.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hit by a train.</b>					
20c. TIME OF INJURY Month, Day, Year <b>7:55PM</b> <b>7-1-60</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Perryville, Maryland</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R. C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>R. C. DODSON,</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>7/5/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Wayne, Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington &amp; Son</i>				ADDRESS <b>Pennington &amp; Son, Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 11 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1959

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Birth		1914	
Place of Birth		Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date of Death		1959	
Time of Death		10:00 AM	
Place of Death		Home	
Signature of Coroner		[Signature]	
Date of Certificate		1959	
Time of Certificate		10:00 AM	
Place of Certificate		Baltimore, Maryland	
Signature of Registrar		[Signature]	
Date of Registration		1959	
Time of Registration		10:00 AM	
Place of Registration		Baltimore, Maryland	

7901

## CERTIFICATE OF DEATH

Reg. Dist. No.

07895

Item 8 Film 269 8-15-60 et

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton, R.D.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Kramak</i> Last <i>Kramak</i>		4. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1960</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 4, 1887</i>	9. AGE (In years lost birthday) <i>83</i> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Kramak</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>151X</i>		INFORMANT <i>Mary Mark (Daughter)</i>		Address <i>2065 Strand St. Wilm. Del.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emaciation, severe</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastatic carcinoma</i> DUE TO (c) <i>Carcinoma of the Stomach</i> INTERVAL BETWEEN ONSET AND DEATH <i>over 1 year</i> <i>years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 27, 1960</i> to <i>July 31, 1960</i> , that I last saw the deceased alive on <i>July 31, 1960</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Tillman D. Johnson</i> M.D. <i>123 S. Sengerly Ave</i>							
PHYSICIAN'S NAME (Type) <i>Tillman D. Johnson</i> <i>Elkton Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/3/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Immaculate Conception Cemetery, Elkton, Md.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i>		ADDRESS <i>Elkton, Md.</i>		24a. REC'D BY REGISTRAR <i>AUG 8 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filled with the funeral director.

VR A15 (4)  
15M 9/59

7923

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07896

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>14yrs.6mo.29days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Charles</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Route 1, Box 62</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J.</b> Last <b>LAWSON</b>				4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-22-00</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Lawson (deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ann Herron (deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I unknown</b>		17. INFORMANT Address <b>Mrs. Goldie Lawson, Mt. Hope, West Virginia (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fibrosis of myocardium due to infarction (old)</b> DUE TO <b>Years</b> (c) <b>Arteriosclerotic heart disease</b> DUE TO <b>Years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH Seconds</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>November 10 1945</b> to <b>July 9 1960</b> and that death occurred at <b>8:30am</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A. L. MOONEY</b>				22b. DATE SIGNED <b>7-13-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, Asst. Pathologist, V.A. Hospital, Perry Point, Md.</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>7/21/60</b>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>	
23d. LOCATION (City, town, or county) (State) <b>Havre de Grace, Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Remington &amp; Son, Havre de Grace, Md.</b>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Krause</b>	
DATE <b>JUL 21 '60</b>							

1953

CERTIFICATE OF DEATH

1953

Name: [illegible]  
 Sex: [illegible]  
 Date of Birth: [illegible]  
 Date of Death: [illegible]  
 Cause of Death: [illegible]  
 Place of Death: [illegible]  
 Signature: [illegible]  
 Date: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit R.D.</b>		c. LENGTH OF STAY in 1b <b>2 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit R.D.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clarence Layfield</b>				4. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>19 60</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-17-1899</b>		9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>		11. BIRTHPLACE (State or foreign country) <b>Greenwood Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James S. Layfield</b>				14. MOTHER'S MAIDEN NAME <b>Rose C. Truitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>W.W.2</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Hazel Preistley, Bx. 1410 Cannon, Del.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>W. C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>7-5-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-8-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Vernon E. McMillen</b>				ADDRESS <b>Rising Sun Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 11 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7902

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07898

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY <del>Queen Anne</del> Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Passing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 14X-2	
3. NAME OF DECEASED (Type or print) Edward Ellis Mann		4. DATE OF DEATH Month 7 Day 21 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1934
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw Mill Employee		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Napoleon Mann		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK.		16. SOCIAL SECURITY NO.	
17. INFORMANT Wilford T. Holden, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lacerated face from chin to right side of cheek 816X DUE TO under nose also left upper cheek left eye lid. Conditions, if any, which gave rise to immediate cause (b) Fracture of nose with puncture wound Fracture of upper and lower maxilla right clavicle (c) crushed right upper chest with puncture wound right chest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit a oil truck with automobile	
20c. TIME OF INJURY Month, Day, Year 6.30 7 21 60 Hr. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work Rroute 213 Elkton Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 7-21-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-60	
22c. NAME OF CEMETERY OR CREMATORY Church Hill Cem.		22d. LOCATION (City, town, or county) Church Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Dondy 172 Doo ELKTON, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7903

Item 4 Film 4289 8-22-60 et

07899

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospit 1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Lester</b> Last <b>Murphy</b>				4. DATE OF DEATH Month <b>7</b> Day <b>25</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-20-1893</b>		9. AGE (In years lost birthday) <b>66</b> yrs.	10. IF UNDER 1 YEAR Months <b>11</b> Days <b>25</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Veterans Admin.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Dennison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>W.W. 1</b>		17. INFORMANT <b>Mrs. Carrie Jones Murphy, Charlestown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Left ventricular failure(pulmonary edema)</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO <b>H. C V D.</b> (c) <b>" "</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b> G. A. S. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-25-59</b> 19 to <b>7-25-60</b> 19, that (I) (we) last saw the deceased alive on <b>April 24 1960</b> , and that death occurred at <b>11:45 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Luis M. Guza</b>				22b. DATE SIGNED <b>7-28-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Luis. M. Guza, M.D.</b>				22d. ADDRESS <b>Cecil Ave., North East, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-29-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Charlestown Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>Charlestown Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R Grant</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

BP

7003

CERTIFICATE OF DEATH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

(M)

REPORTER

H. C. D.

ELIZABETH KELLY

D. A. B.

7-22-60

6-22-59

11.14.11

7-2-60

COOK, R. W. NORTH HAVEN, CONNECTICUT

JAMES W. G. NEW YORK

4061 30

2-1-60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07900

Reg. Dist. No.

7925

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>ALLEGHENY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b>			c. LENGTH OF STAY IN 1b <b>16yrs2mo26days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pitcairn</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>425 Third Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>W.</b> Last <b>NASER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/93</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Phillip Naser</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Hemphill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT <b>Mary Naser (W)</b> , 425 Third St. Pitcairn, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured left ventricle.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General arteriosclerotic heart disease.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R. C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R. C. DODSON</b>				DATE SIGNED <b>7/8/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BRUSH CREEK</b>		22d. LOCATION (City, town, or county) (State) <b>Westmoreland County, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Flemington &amp; Son</i>				ADDRESS <b>Flemington &amp; Son, Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 14 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register, prior to burial or cremation, as required.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. OCCUPATION [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. DATE OF BIRTH [Faint text]	
7. PLACE OF DEATH [Faint text]		8. DATE OF DEATH [Faint text]	
9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF MEDICAL EXAMINER [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF CORONER [Faint text]		14. SIGNATURE OF JURY [Faint text]	
15. SIGNATURE OF JURY [Faint text]		16. SIGNATURE OF JURY [Faint text]	
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73. SIGNATURE OF JURY [Faint text]		74. SIGNATURE OF JURY [Faint text]	
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77. SIGNATURE OF JURY [Faint text]		78. SIGNATURE OF JURY [Faint text]	
79. SIGNATURE OF JURY [Faint text]		80. SIGNATURE OF JURY [Faint text]	
81. SIGNATURE OF JURY [Faint text]		82. SIGNATURE OF JURY [Faint text]	
83. SIGNATURE OF JURY [Faint text]		84. SIGNATURE OF JURY [Faint text]	
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87. SIGNATURE OF JURY [Faint text]		88. SIGNATURE OF JURY [Faint text]	
89. SIGNATURE OF JURY [Faint text]		90. SIGNATURE OF JURY [Faint text]	
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97. SIGNATURE OF JURY [Faint text]		98. SIGNATURE OF JURY [Faint text]	
99. SIGNATURE OF JURY [Faint text]		100. SIGNATURE OF JURY [Faint text]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7905

CERTIFICATE OF DEATH

07901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. #1 Elkton				c. LENGTH OF STAY IN 1b 22 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLIFFORD BUDDAN OREM				4. DATE OF DEATH Month July Day 26 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 2, 1890	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher				10b. KIND OF BUSINESS OR INDUSTRY Meat		11. BIRTHPLACE (State or foreign country) Camden, New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Orem				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 221-03-1782			
17. INFORMANT Address Florence S. Orem Same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intestinal obstruction 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 8 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe pulmonary emphysema and arteriosclerotic C-V disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 18, 1960, to July 26, 1960, that I last saw the deceased alive on July 26, 1960, and that death occurred at 11:30 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) 233 E. Main Street Elkton Maryland			
DATE SIGNED 7/27/60							
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-60		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William J. Warwick Newark, Delaware				24a. REC'D BY REGISTRAR DATE JUL 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

WILLIAM J. WARWICK

7902

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BATHING

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7906

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07902

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Del. b. COUNTY N. Castle ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 46X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital D.O.A.				d. STREET ADDRESS 1109 Chestnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY First Middle Last J. PIATKOWSKI				4. DATE OF DEATH Month Day Year July 24, 1960 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27, 1912		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Piatkowski				14. MOTHER'S MAIDEN NAME Frances Ciesznajewski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 2		17. INFORMANT Address Mrs. Frances Smolka Wilm, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 902.8 Fracture of Neck DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped off pier into shallow water					
20c. TIME OF INJURY Hour 8:20 PM Month, Day, Year 7/24 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elkmore		20f. (City or town) (County) (State) Elkton, RD Cecil Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				DATE SIGNED July 25, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-27-60	22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Wilmington, Del.			
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Donald M. De Elkton, Md.		24a. REC'D BY REGISTRAR DATE JUL 27 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kram	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.



7907

CERTIFICATE OF DEATH

07903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecil</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesertown</u> 148-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home Nursing Home</u>		d. STREET ADDRESS <u>624 W. 1 High St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret May Rash</u>		4. DATE OF DEATH Month Day Year <u>July 2 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-1888</u>
9. AGE (In years, last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house keep.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Queen Anne Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas Rash</u>		14. MOTHER'S MAIDEN NAME <u>Anna Catherine Gorman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs W<sup>m</sup> H. Pennig</u>		Address <u>Chesertown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>severe arteriosclerotic heart disease with failure, Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>  <u>years.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 15</u> , 19 <u>60</u> , to <u>July 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2 July</u> , 19 <u>60</u> , and that death occurred at <u>8:00A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>2 July 60</u>	
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u>		<u>Cecilton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/4/00</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Millington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Millington, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>		ADDRESS <u>Chesertown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7908 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07904

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Visiting	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS Honey Brook R.D. 22	
3. NAME OF DECEASED (Type or print) Theodore Middle Last Theodorore Everett Refford		4. DATE OF DEATH Month 7 Day 4 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1912
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motor Room Op.		10b. KIND OF BUSINESS OR INDUSTRY Lukens Steel	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME no information		14. MOTHER'S MAIDEN NAME Elsie Refford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 189-07-7749	
17. INFORMANT Mrs. Ther. E. Refford, Honey Brook, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Had attack 4 years ago Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Coatesville Chester Co., Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	
24a. REC'D BY REGISTRAR ELKTON, Md		DATE JUL 6 '60	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1987

Name of Deceased		Sex		Age	
John A. Smith		Male		45	
Date of Death		Place of Death		Cause of Death	
10-15-87		Home		Heart Disease	
Time of Death		Manner of Death		Signature of Examiner	
10:00 AM		Natural		[Signature]	
Occupation		Education		Residence	
Teacher		High School		123 Main St.	
Marital Status		Previous Marriages		Social History	
Married		None		No Alcohol, No Drugs	
Date of Birth		Place of Birth		Medical History	
10-15-42		Maryland		Hypertension, Diabetes	
Date of Admission		Date of Discharge		Date of Death	
10-10-87		10-12-87		10-15-87	
Hospital Name		Physician Name		Signature of Physician	
St. Mary's Hospital		Dr. J. Doe		[Signature]	
Room Number		Bed Number		Signature of Coroner	
101		10		[Signature]	
Date of Autopsy		Place of Autopsy		Signature of Pathologist	
10-18-87		Hospital		[Signature]	
Autopsy Number		Autopsy Report		Signature of Coroner	
101-10		See Report		[Signature]	
Date of Report		Signature of Coroner		Signature of Registrar	
10-20-87		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7926

07905

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 46 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Susquehanna Ave.		d. STREET ADDRESS Susquehanna Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Wilber Reynolds		4. DATE OF DEATH Month July 31 Day Year 60 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1885
9. AGE (In years birth day) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Reynolds		14. MOTHER'S MAIDEN NAME Katherine Shutt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-5723	
17. INFORMANT Address Sarah E. Reynolds, Perryville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Arterio Sclerosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocarditis -		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 months 4 yrs -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 17, 1960, to July 31, 1960, that (I) (we) last saw the deceased alive on July 31, 1960, and that death occurred at 2 M, from the causes and on the date stated above.			
22a. SIGNATURE Clarence I. Benson M.D.		22b. DATE SIGNED Aug 2-1960	
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.		22d. ADDRESS Port Deposit, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-3-1960	
23c. NAME OF CEMETERY OR CREMATORY Angel Hill		23d. LOCATION (City, town, or county) (State) Havre De Grace, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leela Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7927 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07906  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McKeesport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 804 Haslage Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HARRY (NMT) ROBINSON		4. DATE OF DEATH Month Day Year July 28 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 4, 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Sadie Farro	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry Robinson, Jr.		804 Haslage St., McKeesport, Penna. (Son)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Peritonitis with tumor of large Bowel DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. DODSON, M.D.		DATE SIGNED 7-28-60	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/30/1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Vernon		22d. LOCATION (City, town, or county) (State) McKeesport, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Hennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE AUG 10 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED'S NAME		SEX		AGE	
JOHN J. JOHNSON		MALE		45	
RESIDENCE		OCCUPATION		DATE OF DEATH	
1234 Main St., Baltimore, Md.		Carpenter		Jan 15, 1950	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
Myocardial infarction with coronary artery disease		Natural		Home	
HISTORY OF PRESENT ILLNESS		PREVIOUS ILLNESSES		MEDICAL HISTORY	
Patient complained of chest pain and shortness of breath on Jan 10, 1950.		Hypertension, treated with medication.		No previous heart disease.	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGIC EXAMINATIONS	
Chest: Clear. Heart: Enlarged. Lungs: Clear.		ECG: Abnormal. X-ray: Abnormal.		ECG: Abnormal. X-ray: Abnormal.	
TREATMENT		POST-MORTEM EXAMINATION		SIGNATURE OF EXAMINER	
None.		None.		J. J. Johnson, M.D.	
FAMILY HISTORY		SOCIAL HISTORY		DATE OF EXAMINATION	
None.		None.		Jan 15, 1950	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7909

Reg. Dist. No.

07907

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>Elk Manor Farm</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PEGGY</b> Middle <b>SUE</b> Last <b>SEXTON</b>				4. DATE OF DEATH Month <b>7-</b> Day <b>23</b> Year <b>19 60</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-24-59</b>	
9. AGE (In years last birthday) <b>14 Mos.</b>		IF UNDER 1 YEAR Months <b>14</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Sexton</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Riggs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Fred Sexton</b> Address <b>North East, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound fracture of the right and left</b> DUE TO <b>side of skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>child was backed over by a car</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>child was backed over by a car</b>					
20c. TIME OF INJURY Hour <b>12:37</b> o. m. <b>7-23</b> p. m. <b>19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>North East, Cecil Co., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. C. DODSON</b>				DATE SIGNED <b>7-23-60</b>			
EXAMINER'S NAME (Type) <b>R. C. DODSON</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-26-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Meth. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cherry Hill, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>				ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 27 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>William L. Knaus</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7:00

NAME OF DECEASED Cecil		AGE 40	
SEX Male		RACE White	
DATE OF BIRTH 1900		PLACE OF BIRTH North East, Md.	
OCCUPATION None		EDUCATION High School	
MARRIAGE Married		SPOUSE None	
DATE OF MARRIAGE 1920		PLACE OF MARRIAGE North East, Md.	
DATE OF DEATH 1930		PLACE OF DEATH North East, Md.	
CAUSE OF DEATH Disease of the right and left		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. C. DeLeon		SIGNATURE OF MEDICAL EXAMINER J. C. DeLeon	
DATE OF SIGNATURE 1930		DATE OF SIGNATURE 1930	
PLACE OF SIGNATURE North East, Md.		PLACE OF SIGNATURE North East, Md.	

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7910

### CERTIFICATE OF DEATH

07908

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Clarence</u> Middle <u>Shivery</u> Last <u>Shivery</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>3</u> Year <u>19 60</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1895</u>		
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Shivery</u>				14. MOTHER'S MAIDEN NAME <u>Marcella Ferguson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>717-07-5344</u>		INFORMANT <u>Mrs. Elwood Logan</u>		Address <u>North East, Md.</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 27</u> , 19 <u>60</u> , to <u>July 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>60</u> , and that death occurred <u>5:11 a.m.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>233 E. Main Street</u>		DATE SIGNED <u>7/3/60</u>		
PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS, JR., M.D.</u>				<u>Elkton, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North East Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East, Md.</u>		24a. REC'D BY REGISTRAR <u>Jul 7 1960</u>		
				DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		

CERTIFICATE OF DEATH

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DEPARTMENT OF HEALTH, MASSACHUSETTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 268 8-2-60 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7928 CERTIFICATE OF DEATH

07909

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>17 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>PROCTOR</b> Last <b>SHURE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1916</b>
9. AGE (In years last birthday) <b>44 yrs.</b>		10. IF UNDER 1 YEAR Months <b>44</b> Days <b>17</b> Hours <b>17</b> Min. <b>17</b>	11. IF UNDER 24 HRS. Months <b>44</b> Days <b>17</b> Hours <b>17</b> Min. <b>17</b>
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>Laboratory Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George M. Shure</b>		14. MOTHER'S MAIDEN NAME <b>Emily McCay</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218 03 7939</b>	
17. INFORMANT <b>Mrs. Ellen Shure (Wife)</b>		Address <b>Port Deposit, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA- FOLLOWING OPERATION</b> DUE TO <b>RIGHT UPPER LOBE LOBECTOMY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>TUBERCULOSIS, PULMONARY, RIGHT UPPER LOBE, ACTIVE - Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 To 5 Days</b> <b>7 Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>10:30 PM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1960</b> to <b>July 22, 1960</b> , that (I) (we) last saw the deceased alive on <b>July 22, 1960</b> , and that death occurred at <b>10:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James L. Garey</b>		22b. DATE SIGNED <b>7-23-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES L. GAREY, M.D.</b>		22d. ADDRESS <b>VAH, PERRY POINT, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rural</b>		23b. DATE THEREOF <b>7-26-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>		23d. LOCATION (City, town, or county) (State) <b>Colora, Md. Rural</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Pettus &amp; Son</b>		24b. ADDRESS <b>Perryville, Md.</b>	
25a. REC'D BY REGISTRAR <b>JUL 26 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

7028



CERTIFICATE OF DEATH

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Local

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7929

## CERTIFICATE OF DEATH

Reg. Dist. No.

07910

1. PLACE OF DEATH o. COUNTY <b>CECIL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>CECIL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELK MILLS</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELK MILLS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>REBECCA</b> Last <b>SIMPERS</b>				4. DATE OF DEATH Month <b>7/</b> Day <b>3/</b> Year <b>19 60</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/ 23/ 1871</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>DEL.</b>	
13. FATHER'S NAME <b>JOHN SETH</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH MARKEE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-14-1634</b>		17. INFORMANT <b>HANNAH SIMPERS</b>		Address <b>ELK MILLS, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho - pneumonia</b> <b>4-4-2 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-vascular renal disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Herbert Bobo</b> ADDRESS (Street, city or town, state) <b>230 E. Main st</b> DATE SIGNED <b>6/4/60</b> PHYSICIAN'S NAME (Type) <b>Elkton Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/6/ 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CHERRY HILL CEM.</b>		22d. LOCATION (City, town, or county) <b>CHERRY HILL MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Benjamin M. Miller</b>				ADDRESS <b>RISING SUN, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 7 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			



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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,  
page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7911

## CERTIFICATE OF DEATH

07911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest H. Slade		4. DATE OF DEATH July 23, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1883
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Slade		14. MOTHER'S MAIDEN NAME Sarah Norman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Box 218 Mrs. Lily B. Slade, Elkton, Md. R.D.3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Carcinoma of the rectum DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) DUE TO (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 23, 1960, and that death occurred at 11:05 PM, from the causes and on the date stated above.		DATE SIGNED 7/24/60	
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 E. Main Street Elkton, Maryland	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/26/60	
22c. NAME OF CEMETERY OR CREMATORY Gracelawn Memorial Park, Wilmington, Delaware		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JUL 29 '60		Charles L. Hines	

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only one within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7912

CERTIFICATE OF DEATH

Reg. Dist. No.

07912

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>2 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DEVINE CONV. HOME</u>				d. STREET ADDRESS <u>1233-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JERRI SWIFT</u> First Middle Last <u>JERRI</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1866</u>	9. AGE (In years lost birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOHN BALDWIN</u>				14. MOTHER'S MAIDEN NAME <u>JANE SHENBERGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		INFORMANT Address <u>Mrs.adio cloman Bel Air, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arteriosclerosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10-13-45</u> (c) <u>6-11-03</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>55</u> , to <u>7/29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/15</u> , 19 <u>60</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George J. [Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>7/29/60</u>			
PHYSICIAN'S NAME (Type) <u>George J. [Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-31-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>		22d. LOCATION (City, town, or county) (State) <u>Stewart Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth [Signature]</u> ADDRESS <u>Stewarttown Pa</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. [Signature]</u>	

CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7913

CERTIFICATE OF DEATH

Reg. Dist. No. 07913

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton Rural</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital Elkton, Md.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle Last <b>Veasey</b>				4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 14, 1906</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Work in Chrysler Auto Parts Plant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Morris Veasey</b>				14. MOTHER'S MAIDEN NAME <b>Maryn A. Moore</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-03-4703</b>		INFORMANT Address <b>Mrs Martha Z. Veasey Elkton Rd 5 Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease with Mitral stenosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>20 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>58</b> , to <b>20 July</b> , 19 <b>60</b> at I last saw the deceased alive on <b>20 July</b> , 19 <b>60</b> , and that death occurred at <b>11:00AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.				22. July-60			
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>				<b>Cecilton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-24-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Cecil Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b> ADDRESS <b>North East Maryland</b>				24a. REC'D BY REGISTRAR <b>JUL 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William L. H. H.</b>	

CERTIFICATE OF DEATH

1913

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Date of birth: \_\_\_\_\_

4. Place of birth: \_\_\_\_\_

5. Date of death: \_\_\_\_\_

6. Cause of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Signature of physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Signature of informant: \_\_\_\_\_

11. Date of filing: \_\_\_\_\_

x

12. Date of filing: \_\_\_\_\_

13. Signature of registrar: \_\_\_\_\_

14. Signature of informant: \_\_\_\_\_

15. Date of filing: \_\_\_\_\_

16. Signature of registrar: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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7930

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07914

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>10yrs.9mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>229 Myrtle Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>H.</b> Last <b>WALTERS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/10/1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>9</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Walters</b>		14. MOTHER'S MAIDEN NAME <b>Julia Smothers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Katherine Bates, sister, 229 Myrtle Avenue</b>		Address <b>Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of the liver Laennec's type</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Leiomyosarcoma of the stomach</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>October 13, 1949</b> to <b>July 13, 1960</b> and that death occurred at <b>7:10am</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. L. Garey</b>		22b. DATE SIGNED <b>7-19-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. L. GAREY, Clinical Pathologist</b>		22d. ADDRESS <b>V.A. Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>7/19/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JUL 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

• 202 •

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07915

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>6yrs6mos.3days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2214 W. North Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>WILSON</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-8-88</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handy man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Odd jobs</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Annie Washington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1</b>	
17. INFORMANT <b>2214 W. North Ave.,</b> <b>Gladys Dorsey, Baltimore, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Arteriosclerosis, Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Severe Malnutrition And Arteriosclerotic Cerebral Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe Malnutrition And Arteriosclerotic Cerebral Vascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 26, 1959</b> to <b>July 29, 1960</b> , that the cause of death was <b>Arteriosclerotic Heart Disease</b> , and that death occurred at <b>11:05 AM</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>Albert L. Mooney</b>		22b. DATE SIGNED <b>7-30-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALBERT L. MOONEY, M.D.</b>		22d. ADDRESS <b>VAH, Perry Point, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/3/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Rice</b>		25a. REC'D BY REGISTRAR <b>AUG 1 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles A. Rice</b>			

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CENTRAL BANK OF NORTH

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Statement of Assets

Statement of Liabilities

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